# MEDICAL PRIVACY AND THE RIGHT TO KNOW*

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IN discussing the diffusion of health information to the public, one cannot—at least in 1987—avoid dealing with the right of privacy and the right to know in a medical context. Inevitably, inescapably, ineluctably, the question arises: When is medical information about a patient nonconfidential?

This is an old question, as old as the practice of medicine, but it presses in on us today with new immediacy and in new contexts. Three examples or variants of the central question have been in the news recently. In the controversial Baby M surrogate mother case, the New Jersey trial judge overruled an objection by Mary Beth Whitehead's lawyer to the admissibility of testimony about statements made by his client in confidence to a family therapist. Was the trial judge correct? President Ronald Reagan has had various medical procedures while in office (treatment for gunshot wound, intestinal cancer, prostate problems). William Casey, former Director of the Central Intelligence Agency, continued to serve in a highly sensitive position while afflicted with prostate cancer and a brain tumor. How much medical information about high government officials should be made public? The spread and fear of acquired immune deficiency syndrome (AIDS) have led to proposals for blood tests, voluntary or mandatory. How do such tests affect medical privacy and the right to know? These three concrete examples supply a backdrop, a real-life setting, for looking at the problem of medical privacy and the right to know.

The appropriate method of analysis is to identify and to explore the relevant competing considerations. What is privacy? What is the right to know? These are shorthand, catch-all phrases that we all tend to use loosely in common speech. But loose language breeds fuzzy thinking. We have to be more precise and examine the limits of each concept, its source, and its history. Such an approach makes analysis more meaningful.

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Once the countervailing considerations are laid bare, we can try to apply our results to the three examples. Here, as in so many other areas of life, the process will be one of balancing. Absolutes are rare in this area. The task, recognized almost from the start of rational medicine, is to balance important competing interests—each of which is valuable—to decide in a specific instance which one should prevail. Just as many medical treatments entail careful balancing—a weighing of risks and benefits—so too does analysis of the pros and cons of medical privacy and the right to know.

## Medical Privacy

Privacy is one of those emotion-laden buzz words that trigger strong associations in all of us. In a complex modern world filled with data banks, credit information, tax returns, sophisticated and intrusive electronic equipment, the notion of privacy is attractive, if not essential. We all want a zone where what we do or say is not public property. In a famous passage, Supreme Court Justice Louis Brandeis once referred to the right of privacy as the "right to be left alone—the most comprehensive of rights and the right most valued by civilized man."[1]

But thus to describe privacy fails to aid our inquiry in a meaningful way. No one seriously doubts the importance of privacy as a value; everyone pays lip service to it. The real question is when, if ever, privacy should yield to accommodate other, perhaps equally important or conceivably even more precious, values. For the answer, we have to look at the sources, the meaning, the historical and contemporary understanding of privacy in the medical and broader contexts. We need to find guides in the past and the present to help us cope with the future. By looking at how privacy is treated in law and medicine, we may locate some benchmarks that will help us find our bearings in this field.

*Medical ethics.* In trying to grasp the meaning of privacy in the medical context, we should look first at the most natural and obvious source: medical ethics. The concept of medical confidentiality has an ancient lineage. It has always reflected, to a greater or lesser extent, the general understanding of the medical profession.

There are two essential reasons for medical privacy. First, confidentiality encourages full disclosure by a patient, which is necessary for proper treatment. Second, privacy enhances human dignity by preventing humiliation, disgrace, and embarrassment. These rationales have guided the medical profession's approach from the start, and continue to do so.

One of the earliest and best examples of the medical profession's approach to this issue comes from the Periclean Age of Greece. The Hippocratic Oath, the fountainhead of so much of medical ethics, explicitly refers to confidentiality. In the words of the 2,500 year old Oath: "And whatever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets."[2] But even the Hippocratic Oath's protection for confidentiality is less than absolute. The Oath only applies to "what should not be published abroad." Thus the classic formulation recognizes a balancing approach and leaves unanswered the hard question: What medical information should or should not be made public? Medical ethics is therefore only the starting point; further analysis is necessary.

*Physician-patient privilege.* One way that law tries to deal with medical confidentiality is by the so-called physician-patient privilege. Strictly speaking, this privilege is a rule of evidence, which means that it regulates the admissibility of certain types of evidence in legal proceedings. But in a broader sense the law's physician-patient privilege is a legal accommodation for medical confidentiality.

Public perception of the physician-patient privilege differs greatly from the legal reality. In law, the privilege has a shaky and uncertain status. According to the leading recent treatise on the law of evidence, "Legal scholars have been virtually unanimous in their condemnation [of the privilege]. . . . The rationale for a privilege is absent."[3] Moreover, continues the author (an eminent federal judge and former law professor), states "have whittled away at the privilege so that its scope has been considerably reduced. Numerous nonuniform exceptions have evolved which have rendered the privilege 'substantially impotent' and difficult to administer."[4] The physician-patient privilege has, in short, given way to "the overriding need for full disclosure when litigation arises."[5]

Such a description of the law may surprise physicians and members of the public. Yet history confirms the balancing approach. There was no physician-patient privilege at common law, that is, the case-by-case process whereby judges build on precedents. The privilege is purely a creature of statute. New York passed the first such statutory privilege in 1828, and by now some three fourths of the states have on their statute books some form of the physician-patient privilege.[6]

Contemporary legal attitudes toward the physician-patient privilege

emerged clearly in the early 1970s in connection with the Federal Rules of Evidence. Before 1975 a uniform code of evidence had never been used in federal courts. In 1971 an advisory committee submitted a proposed set of evidence rules. The draft contained no proposal for a general physician-patient privilege, although it did recommend a patient-psychotherapist privilege.[7] But even that limited recommendation fell by the wayside. In the code ultimately enacted by Congress in 1975 there is no specific physician-patient privilege. Instead, Rule 501 of the Federal Rules of Evidence provides that all privileges "shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason" or "shall be determined in accordance with State law."

With no physician-patient privilege specified in the new Federal Code of Evidence, the exception-riddled state law still controls. Among the exceptions to the privilege under state law are: proceedings for hospitalization or commitment, examinations by court order, when evidence is an issue in the case, will cases, insurance policy cases, required reports (venereal disease, gunshot wounds, child abuse), furtherance of crime or fraud, medical malpractice suits, and criminal prosecutions. These exceptions to the physician-patient privilege vary from state to state and are not an exclusive list.

The current status of the physician-patient privilege is highly instructive. Its many exceptions represent countervailing considerations of public policy that expose the inherent limitations on an absolute view of medical privacy. In the litigation setting, medical privacy often yields to the quest for truth. But full disclosure in a lawsuit is only one type of consideration to be set off against medical privacy. Other contexts present other kinds of countervailing considerations. The important thing is how the tension is resolved through balancing medical privacy against public policy.

*Privacy tort.* Although privacy is an old concept, the creation of legal liability for invasion of privacy is a relatively new development. Most of the legal growth in this field has occurred in the 20th century. As of now, the law recognizes a tort (civil wrong) for invasion of privacy in certain situations. The standards and elements for such civil liability provide us with further guidelines for balancing privacy and the right to know in the medical field.

Generally speaking, American law recongizes four distinct categories of invasion of privacy torts.[8] The first type consists of the appropriation, for the defendant's benefit or advantage, of the plaintiff's name or likeness. The second form of invasion of privacy involves publicity that puts the plaintiff in

a false light in the public eye (this tort resembles libel). The third type of invasion of privacy consists of an unreasonable and highly offensive intrusion upon the seclusion of someone else. Another fourth group of cases has found a cause of action in publicity, of a highly objectionable kind, given to private information about the plaintiff, even though it is true and no legal claim would exist for defamation. Of these four categories, the last two—unreasonable intrusion and public disclosure of private facts—are the most revelant for our purposes.

Unreasonable intrusion involves intentional interference with another's interest in solitude or seclusion, either as to his person or to his private affairs or concerns.[9] Its essence is prying and physical intrusion. Illegal blood tests,[10] urine tests, and stomach pumping could be the premises for such a claim of invasion of privacy. Likewise, so might a photograph of a patient confined to a hospital bed,[11] even if the patient were participating in an important new medical procedure.

Public disclosure of private facts is probably the most analogous for a discussion of medical privacy and the right-to-know. Four requirements must be met for legal recovery: The disclosure of the private facts must be a public disclosure and not a private one. The facts disclosed to the public must be private facts, and not public ones. The matter made public must be one which would be highly offensive and objectionable to a reasonable person of ordinary sensibilities. And, finally, the public must not have a legitimate interest in having the information made available.[12]

These four requirements themselves contain a crucial element of balancing. The first three requirements are established by the common law. But the fourth requirement reflects the interest in the right to know. The right to know here embodies the restrictions imposed on the common law recovery by decisions protecting freedom of speech and the press under the First Amendment to the Constitution. Thus, this tort requires a balancing of privacy and the right to know, explicitly recognizing that privacy is not an absolute.

*Constitutional pressures.* Along with the tort of invasion of privacy, our generation has witnessed the growth of a *constitutional* right of privacy relevant to medical confidentiality. The watershed legal event came in 1965, when the Supreme Court decided the case of *Griswold v. Connecticut.*[13] *Griswold* involved a vestigial state law prohibiting married couples from us-

ing or receiving information about contraceptives. Finding no explicit or specific constitutional right of privacy, a majority of the Court in *Griswold* reasoned that "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance."[14] The anticontraceptive law in *Griswold*, ruled the Court, violated a "penumbral right" of privacy, radiating from several specific constitutional provisions creating a "zone of privacy."[15]

The creative thrust of *Griswold* is that, even without an explicit or specific right of privacy mentioned in the Constitution, there are certain areas of life beyond the reach of government intrusion. Whether based on *Griswold's* controversial "penumbra theory" or the liberty protected by the Fifth and Fourteenth Amendments, the idea is to ward off interference, to preserve an area of life independent of social control. It embodies the desire not to be impinged upon, to be left to oneself, to prevent the encroachment of public authority. Its purpose is to reserve a free area for action over which neither the state nor any authority must be allowed to interfere with an individual's activity.[16]

Since *Griswold* was decided in 1965, the courts have interpreted the constitutional right of privacy there recognized to protect the autonomy of the individual to make certain important decisons of a very personal nature.[17] This protected interest in personal autonomy generally relates to matters of marriage, procreation, contraception, family relationships, child rearing, and education. Certain cases in this line have been extremely controversial, such As *Roe v. Wade* (the 1973 abortion decision)[18] and the 1986 decision holding that homosexuality was not protected by a constitutional right of privacy.[19] Nonetheless, the Supreme Court said in 1977 that, "The concept of a constitutional right of privacy still remains largely undefined."[20]

This emerging constitutional right of privacy, undefined though it may be, has already had an impact on medical confidentiality. The Supreme Court has recognized a right of privacy in the physician-patient context of a woman patient's decision to have an abortion without parental or spousal consent.[21] On the other hand, the Supreme Court has more often used a balancing approach. It upheld a state law requiring information on all prescriptions for certain drugs to be computerized and to be made available to certain health and investigatory personnel. The plaintiffs in that case had argued that the patient identification requirement destroyed their right of privacy. But the Court stressed that there were numerous safeguards in the law intended to protect against wholesale disclosure and that the state's interest in public health was sufficient to warrant limited disclosure. Even so, the Court recog-

nized that one of the "facets [of a constitutional right of privacy] that have been partially revealed, but [whose] form and shape remain to be fully ascertained" is "the right of an individual not to have his private affairs made public by the government."[22]

The net result of the case law is to recognize a constitutional pressure in favor of medical confidentiality. This constitutional pressure is in addition to the pressure of medical ethics, the physician-patient privilege, and the common law. At the same time, however, recognition of a constitutional pressure does not end the analysis. The cases show that countervailing considerations must still be carefully weighed and balanced.

## Right To Know

To end the discussion of privacy on a constitutional note provides a transitional bridge to the right to know, which itself is heavily laden with constitutional arguments. After all, the right to know arises in large part from the First Amendment to the Constitution. Important as the constitutional considerations underlying the right to know are, we cannot overlook other public policy reasons behind the right to know.

To some extent, discussion of the concept of privacy has presaged the competing right to know. The tort of invasion of privacy recognizes a defense based on the public's legitimate interest in having information made available. Similarly, the physician-patient privilege and the constitutional right of privacy are not absolute, but yield on occasion to other more important concerns in a particular situation. The way is thus well prepared for a look at the sources of the right to know.

*The First Amendment.* The starting point of any discussion of the right to know must be the First Amendment. According to that Amendment, "Congress shall make no law abridging the freedom of speech or of the press...." Although worded to prohibit Congress only, it has by virtue of court decisions come to apply to all branches of the federal government and state governments as well. On its face, it seems to protect only the right to speak or publish, but such a narrow interpretation no longer governs.

"It is now well established," said the Supreme Court in 1969, "that the Constitution protects the right to receive information and ideas."[23] A generation earlier the Court had held that, "This freedom [of speech and press]...necessarily protects the right to receive...."[24] In the 1969 case the Court went on to say that, "This right to receive information and ideas, regardless of their social worth...is fundamental to our free society."[25]

This broad interpretation of the First Amendment has been called the

"Meikeljohn theory," named for the late Professor Alexander Meikeljohn. According to Meikeljohn: "The First Amendment does not protect a 'freedom to speak.' It protects the freedom of those activities of thought and communication by which we govern. It is concerned, not with a private right, but with a public power, a governmental responsbility."[26] From this point of view, free speech is not protected for some intrinsic value of speech or individual liberty, but because it is a necessary condition for making informed decisions about matters of government, decisions that all citizens in a democracy are called upon to make. Speech provides information, the raw material from which citizens can make self-governing choices.

Drawing on Meikeljohn's theory, the Supreme Court has over the past 25 years stressed the integral role of free speech in a democratic political system and the need for access to ideas and experiences that citizens require for self-governance. The Court broadened the concept of self-government beyond a narrowly defined political sphere to include the general conduct of one's life. Reversing a line of cases, the Court in 1976, for example, held commercial speech (e.g., advertising) protected on the ground that citizens need a free flow of such information in order to make decisions in their daily lives, indeed, that a citizen's interest in such information "may be as keen, if not keener by far, than his interest in the day's most urgent political debate."[27]

The consequences of this recent development are important and many, only some of which are directly relevant for our purposes. First of all, the recent legal changes establish twin constitutional rights: the right of the public to know and the right of the press to tell all information that arouses public interest. Second, the courts had to deal with "public figures." A public figure includes not only a celebrity, but anyone who has arrived at a position where public attention is focused on him as a person. Such public figures are held to have lost, at least to some extent, their right of privacy. These are the constitutional underpinnings of the right to know.

*Public policy considerations*. Quite apart from the First Amendment, there may be many other reasons to disallow medical confidentiality. In connection with the physician-patient privilege, we have seen how it often gives way to the need for full disclosure in legal proceedings. We have seen in another context how the Supreme Court has acknowledged the state's interest in public health as a legitimate reason for limited disclosure. Indeed, the many exceptions to the physician-patient privilege show the nature of the countervailing considerations: to prevent future crime, to uncover child

abuse, to hospitalize people who cannot care for themselves, etc.

No list of public policy considerations behind the right to know can be exhaustive. Each case must be evaluated in its own context. There must be room for growth, adaptation, and accommodation.

## CONCLUSIONS

The one certain conclusion to be drawn here is that we deal not with absolutes, but with a balancing of interests. The task is to reconcile the tension between privacy and the right to know in the medical context. Perhaps one way to demonstrate this process is to return to the three recent examples taken from the news: the *Baby M* case, health of public officials, and testing for AIDS.

The physician-patient privilege issue in the Baby M case is, at least for our purpose, the easiest to resolve. In overruling the privilege and allowing testimony about the surrogate mother's therapy sessions, the trial judge was on solid ground. The well-accepted rule in custody cases is that such testimony is admissible on two grounds. First, by seeking or contesting custody of a child, a litigant puts into issue her mental and emotional health and well-being, and thereby waives any physician-patient privilege. In addition, the best interest of the child is the overarching consideration of public policy in custody cases and prevails over the physician-patient privilege.

Publicity about the health of public officials is more complicated. A page or two from history may, however, be illuminating. In 1920 President Woodrow Wilson became totally incapacitated by a stroke. Mrs. Wilson and an aide kept the president's condition a secret and ran the country from his bedside. In 1944 President Franklin Roosevelt ran for a fourth term, although he was ill and that illness was known to his personal physician. The physician lied to the public about his patient's condition and helped re-elect F.D.R. In both cases the national welfare and security were endangered, and the public misled.

Human frailty being what it is, high public officials will from time to time have medical problems. These medical problems must have an effect on the ability of these officials to cope with the heavy physical and mental demands of their work. The thought that the head of the Central Intelligence Agency stayed in office while undergoing radiation treatments for cancer without the public knowing compromises the nation's most delicate and sensitive operations. The concern that a patient worried about his medical condition might avoid getting help must be balanced by the general public interest in the

health of high public officials and the necessity that such officials be fit for their jobs. One could argue cogently that, like any public figure, a high public official has waived his privacy to that extent.

We must distinguish here between image and reality. Protecting an official's image in terms of his health may not be in the public interest. After all, no essential bodily function is a source of embarrassment. Anything that threatens his life or his ability to think or act is the public's business.[28]

The AIDS situation is perhaps the most troublesome.[29] In one sense, the use of testing for AIDS resembles testing for other sexually transmitted diseases, which is routinely done as a condition for a marriage license. But such marriage license testing might discourage certain couples from getting married. Moreover, some of the proposed tests would occur in other, nonmarriage license contexts, such as testing of large populations of homosexuals or all employees. Opponents raise the dangers of such testing for a free society together with the loss of confidentiality. But the vital public interest in preventing an epidemic may be the overriding concern here. To be sure, protection for individuals must be given, but the public has a basic right to protect itself against any epidemic, whether caused by a sexually or nonsexually transmitted disease. The bedrock interest in survival of the population must overcome an individual's interest in privacy, though one hopes that a reasonable accommodation can be found.

In the end, there is one fundamental issue for these three examples and all others that are related. That basic issue is the one left unanswered by the Hippocratic Oath. How are we to determine "if [medical information] be what should not be published abroad?" Finding the answer is a daunting but essential task in each case of balancing the right of privacy against the right to know.

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